NEW PATIENT INFORMATION

Name_____Date:_____.

Address:_____

City:_____State:_____Zip:_____Age:_____Birthdate:_____

Home Phone:_____Cell Phone:_____Cell Phone Carrier:_____

Email: _____ Employer: _____

Marital Status: Married ☐ Single ☐ Other ☐ Who referred you to our office:_____

Are your present problems due to an injury? Yes ☐ No ☐ On the Job ☐ Other ☐

Are you now or have you ever been disabled/impaired? (Service or Work?) ☐ Yes ☐ No When: _____

CHIEF COMPLAINT
Please complete a section for each area that is in pain

1. What is your Chief Complaint? _____ .
   A. What type of pain are you experiencing? **Dull/Achy/Sharp/Stabbing/Numbness.**
   B. How often are you experiencing this pain **0/25/50/75/100** % of the day?
   C. On a scale of 0 (no pain) to 10 (worst pain), how would you rate your pain when it is at its worst_____, and at its best_____.
   D. When did the pain begin, _____Is the pain currently getting **Better/Worse/Same**?
   E. What specific actions or positions that **INCREASE** the pain?
      _____.
   F. What specific actions or positions that **DECREASE** the pain?
      _____.
   G. Do you have any numbness or tingling in your arms/hands/legs/feet? If so, explain _____.
   H. What time of the day is the pain at its worst? **Morning/Noon/Afternoon/After Work/ Before Bed.**
2. What is your Secondary Complaint? _____
   I. What type of pain are you experiencing? **Dull/Achy/Sharp/Stabbing/Numbness.**
      _____.
   J. How often are you experiencing this pain **0/25/50/75/100** % of the day?
   K. On a scale of 0 (no pain) to 10 (worst pain), how would you rate your pain when it is at its worst_____, and at its best _____.
   L. When did the pain begin, Is the pain currently getting **Better/Worse/Same**?
   M. Are there any specific actions or positions that **INCREASE** the pain?
      _____ .
   N. Are there any specific actions or positions that **DECREASE** the pain?
   O. Do you have any numbness or tingling in your arms/hands/legs/feet? If so, explain _____
   P. What time of the day is the pain at its worst? **Morning/Noon/Afternoon/After Work/ Before Bed.**

List Medications: _____
List Surgeries and dates: _____

HABITS:

☐ Smoking Packs/Day_____ ☐ Alcohol Cups/Day_____
☐ Coffee Cups/Day_____ ☐ Soda Pop Cups/Day_____

FAMILY HISTORY:

	Diabetes	Heart	Kidney	Cancer	Back
Mother- Living Y ☐ N ☐	☐	☐	☐	☐	☐
Father- Living Y ☐ N ☐	☐	☐	☐	☐	☐
Brother(s) # of _____	☐	☐	☐	☐	☐
Sister(s) # of _____	☐	☐	☐	☐	☐

Have you had any of the following diseases:

☐Alcoholism ☐Anemia ☐Appendicitis ☐Arthritis ☐Cancer ☐Chicken Pox ☐Diabetes ☐Eczema ☐Epilepsy
☐Goiter ☐Heart Disease ☐HIV Positive ☐Influenza ☐Low Back Pain ☐Measles ☐Mental Disorder
☐Mumps ☐Pleurisy ☐ Pneumonia ☐Polio ☐Rheumatic Fever ☐Scoliosis ☐Whiplash

Please place a check in the box if you have experienced the following symptoms in the Past or Present. If a Present symptom, please indicate the number of times in the last month you have experienced that symptom.

	Past	Current	#/month		Past	Current	#/month		Past	Current	#/month		Past	Current	#/month
GENERAL SYMPTOMS				GASTRO-INTESTINAL				EENT				RESPIRATORY			
Headache				Poor Appetite				Poor Vision				Chronic Cough			
Fever				Poor Digestion				Crossed Eyes				Spitting Blood			
Chills				Starvation				Pain in Eyes				Spitting Phlegm			
Night Sweats				Belching and Gas				Deafness				Chest Pain			
Fainting				Nausea				Earache				Difficulty Breathing			
Dizziness				Vomiting				Ear Noises				Genito-Urinary			
Convulstions				Pain over Stomach				Nasal Obstructions				Frequent Urination			
Loss of Sleep				Constipation				Nose Bleeds				Painful Urination			
Fatigue				Diarrhea				Sore Throats				Blood in Urine			
Nervousness				Colon Trouble				Hoarseness				Kidney Infection			
Loss of Weidght				Hemorrhoids (piles)				Hay Fever				Bed Wetting			
Numbness or pain in				Fluid Retention				Asthma				Inability to Control Urine			
arms/hands/legs/feet				Liver Trouble				Frequent Colds				Prostate Problem			
Allergy, to what:				Gout				Enlarged Thyroid				FOR WOMEN ONLY			
Wheezing				Jaundice				Tonsillitis				Painful Periods			
Neuralgia				Gall Bladder Trouble				Sinus Trouble				Excessive Flow			
MUSCLES AND JOINTS				CARDIOVASCULAR				SKIN or ALLERGIES				Irregular Cycle			
Weakness				Rapid Heart Beat				Skin Eruptions				Hot Flashes			
Twitching				Slow Heart Beat				Itching				Cramps/backache			
Stiff neck				High Blood Pressure				Bruising Easily				Vaginal Discharge			
Backache				Low Blood Pressure				Dryness							
Swollen Joints				Pain over Heart				Boils				OTHER			
Tremors				Heart Trouble				Sensitive Skin				Are you pregnant?	Yes	No	
Foot Trouble				Swelling Ankles				Hives or Allergies							
Painful Tail bone				Poor Circulation				Eczema							
Pain between Shoulders				Varicose Veins											
Spinal Curvature				Strokes											
				Palpitations											

Patient Signature _____ Date_____

Guardian Signature _____ Date_____